Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR. AHMED KHALIFA
1415 SOUTH HWY 6, SUITE 400D
SUGARLAND TEXAS 77478

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-B739-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the *Table of Disputed Services*: "Fee Guideline"

Amount in Dispute: $706.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 21, 2009	Professional Medical Services	$706.58	$510.30

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the procedures for professional medical services provided in the Texas workers' compensation system on or after March 1, 2008.
3. The requestor submitted copies of EOBs dated June 9, 2009 and June 10, 2009 both for date of service April 28, 2009. The table of disputed services indicates that date of service April 21, 2009 is in dispute. Therefore the EOBs submitted with this dispute will not be considered in this review. The requestor did not include copies of EOBs for review for date of service April 21, 2009.
4. Request for reconsideration letter date July 23, 2009, states in part "On May 27, 2009 we submitted the medical bill along with the supporting documentation related to the date of service April 21, 2009. However, as of today, 57 days later, we have yet to receive a response. The dispute did not contain EOBs pertaining to the disputed charges. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

Issues

1. Did the requestor bill the services in accordance with 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 (b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.
2. Review of the CMS-1500 indicates that the requestor billed the following CPT codes:
   - 64626–Destr paravertebral nerve c/t
   - 64627–Destr paravertebral nerve c/t, add on
   - 77003-26–Fluoroguide for spine inject
   - 95937–Neuromuscular junction test
   - 20552–Inj trigger point 1/2 muscle
3. Review of the submitted documentation finds that the services were rendered as billed. CCI edits were run to determine if the services were billed in accordance with the requirements of 28 Texas Administrative Code §134.203. CCI edits indicate that CPT code 64626 and component procedure 95937 are unbundled. A modifier is not allowed. Therefore reimbursement is not recommended for CPT code 95937.
4. Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, the procedures are ranked by fee schedule amount and the appropriate reduction is applied to the code(s); 100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report. Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.
5. 28 Texas Administrative Code §134.203(c)(1) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
6. Reimbursement is therefore calculated with the surgery conversion factor of $66.32 and reimbursement is recommended as follows:
   - CPT code 64626 (1 unit)
     Status indicator 2 – 100% reimbursement
     MAR = $409.19
     Amount sought – $321.07
   - CPT code 64627 (1 unit)
     Status indicator 0 – 100% reimbursement
     MAR=$103.68
     Amount sought – $81.36
   - CPT code 77003-26 (2 units)
     Status indicator 9– 100% reimbursement
     MAR=$107.53
     Amount sought – $42.20
   - CPT code 20552 (2 units)
     Status indicator 2 – 50% reduction multiple procedure rule
     MAR=$65.67
     Amount sought – $92.42
7. Review of the submitted documentation finds that requestor is seeking $706.58. Reimbursement for CPT code 95937 of $169.54 is not recommended. The requestor is entitled to reimbursement in the amount of $510.30.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $510.30.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $510.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 3, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.